

Maricopa County  
Benefits Office  
301 W. Jefferson, Suite 201  
Phoenix, AZ 85003



**Maricopa County**

JOHN Q SAMPLE  
123 MAIN STREET  
ANYTOWN, US 12345

Welcome to the Maricopa County Prescription Drug Program.

The plan is administered by Walgreens Health Initiatives (WHI).

The program has two parts:

- Retail Pharmacy Benefit — Choose from thousands of participating pharmacies nationwide.
- Mail Service Pharmacy Benefit — Order your prescriptions and have them delivered right to your door.

*The information explained in this packet is not a guarantee of benefits and may be subject to change. If there is any discrepancy between this information and any other legal documents governing the plan, the legal documents govern.*

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Enclosed are your NEW pharmacy benefit ID cards.

### **This packet includes:**

- Your pharmacy benefit ID cards (attached)
- Partial listing of participating retail pharmacies
- Order Form and pre-addressed envelope for mail service orders
- Tips and information about using your benefit
- Three-Tier Patient Drug Formulary Guide

### **Internet**

Visit our web site at [www.whphi.com](http://www.whphi.com) for the following:

- Formulary information
- Pharmacy locator
- Mail service information
- Mail service registration and prescription refills

### **WHI Member Services**

If you have a question about your pharmacy benefits (for example, copay, eligibility, or location of a nearby participating pharmacy), call WHI Member Services toll-free at 1-800-207-2568.

Monday - Friday, 7 a.m. - 10 p.m. (Central Time)

Saturday - Sunday, 8 a.m. - 4 p.m. (Central Time) and TTY: 1-888-411-0767

**Effective January 1, 2003 - 24 hours a day, 7 days a week**

## Your Cost

When your covered prescriptions are filled under this program, you share a portion of the cost; the plan pays for the rest. Your costs for the program are as follows:

### Retail Pharmacies, up to a 30 Days Supply at any Participating Pharmacy:

Generic: 25% copay (\$2.00 min., \$10.00 max.)  
Preferred: 30% copay (\$5.00 min., \$25.00 max.)  
Non-preferred: 30% copay (\$20.00 min., \$50.00 max.)

### Walgreens Retail Stores 84 - 90 Days Supply:

Generic: 25% copay (\$6.00 min., \$30.00 max.)  
Preferred: 30% copay (\$15.00 min., \$75.00 max.)  
Non-preferred: 30% copay (\$60.00 min., \$150.00 max.)

### Walgreens Mail Service Copays:

Generic: 20% copay (\$6.00 min., \$28.00 max.)  
Preferred: 25% copay (\$15.00 min., \$70.00 max.)  
Non-preferred: 25% copay (\$60.00 min., \$140.00 max.)

**\*Please request a 90 days supply of medication from your physician if appropriate.**

It is standard pharmacy practice (and in some states, it is even required by law) to substitute generic equivalents for brand-name drugs whenever possible.

When you use the mail service or a participating retail pharmacy, you will receive generic substitutes whenever available and allowable.

Under your benefit plan, whenever you or your physician request a brand name drug when a generic substitute is available and allowable, **you will be responsible for the higher brand copayment for each drug.**

## Clinical Prior Authorization Program

Certain prescriptions require "clinical prior authorization," or approval from your plan, before they will be covered. The categories/medications that require clinical prior authorization may include, but are not limited to: acne (topical after age 36), ADHD/narcolepsy (after age 20), anabolic steroids (all types), antifungals, Cyclooxygenase-2 Inhibitor, insomnia (after 90 pills per 144 days), migraine (after 8 nasal sprays, 8 injections or 18 tablets per 25 days), obesity, Proton Pump Inhibitors and Stadol.

To confirm whether you need clinical prior authorization and/or to request approval, call 1-877-665-6609. Please have available the name of your medication, physician's name, phone (and fax number, if available), your member ID number and your group number 512229.

## Specialty Pharmacy

Certain medications used for treating complex health conditions are handled through the WHI Specialty Pharmacy Program. These conditions include but are not limited to: Cystic Fibrosis, Multiple Sclerosis, and Viral Hepatitis. To contact the Specialty Pharmacy Center call: 1-888-782-8443.

## Covered Drugs\*

- Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin
- Disposable insulin syringes/needles

## Drugs Not Covered\*

- Fertility drugs
- Hair loss treatments (for example, minoxidil, Propecia®)
- Nutritional/Dietary supplements
- Over-the-counter (OTC) items

\*This is a *partial* listing of covered and non-covered drugs. Certain prescriptions may require physician confirmation of medical necessity. Please refer to your plan document for details. For specific drug inquiries, contact WHI Member Services at 1-800-207-2568.

## Participating Pharmacies

You can choose from more than 50,000 participating pharmacies. Below are just some of the many pharmacies participating in our nationwide retail network. For additional participating pharmacies, call WHI Member Services at 1-800-207-2568 or visit our web site at [www.whphi.com](http://www.whphi.com).

Acme	Pathmark
Albertsons Pharmacy	Payless
Brooks Pharmacy	Publix Pharmacy
Costco Pharmacy	Randalls
Duane Reade	Rite Aid
Eckerd Drug	Safeway Pharmacy
Fred Meyer	Sav-on Drugs
Freds	Shop Rite Pharmacy
Frys Pharmacy	Shopko
Genovese	Smiths Food & Drug
Hy Vee Pharmacy	Stop & Shop Pharmacy
Kerr Drug	Super D Drugs
K mart	Target
Kroger Pharmacy	Thrifty Drug
Longs Drug Stores	United
Medicap Pharmacy	Wal Mart
Meijer	Walgreens
Osco	Winn Dixie Pharmacy

# Mail Service Pharmacy Tips

## New Prescription(s):

- Complete attached registration form. You may also register yourself (and dependents, if applicable) at [www.whphi.com](http://www.whphi.com).
- New prescriptions must be mailed to the mail service pharmacy.
- For long-term medications you need right away: ask your doctor for two prescriptions—one for a small supply to fill at a participating retail pharmacy, and one for a long-term supply to fill through the mail.
- Most orders are shipped by U.S. Postal Service. Controlled substances may require an adult signature upon receipt. Packaging does not show any indication that medications are enclosed.
- Allow 2 weeks for delivery.
- Emergency prescriptions can be shipped overnight. Please call Customer Service.
- Include payment, if applicable to avoid any delays. Please do not send cash.
- Make checks payable to Walgreens Healthcare Plus.
- Credit cards accepted.
- Refills cannot be transferred from other pharmacies. Request a new prescription from your doctor.

### Mail Pharmacy Customer Service:

1-888-265-1953 (TTY: 1-800-573-1833)

Monday–Friday 7:00 a.m. - 7:00 p.m. (Mountain)

Saturday 7:00 a.m. - Noon (Mountain)

### Refills by Phone:

1-800-RX-REFILL (1-800-797-3345)

(en español: 1-800-778-5427)

### Internet:

[www.whphi.com](http://www.whphi.com)

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**Walgreens Healthcare Plus**



Maricopa County



10400000WHPWHP329123456789

Name JOHN Q SAMPLE

ID 123456789

RxGrp 512229

Int+ WHP

UPI WHP329

MARY

LAURA

TOM

JERRY

ANTHONY

ANGELA

## REGISTRATION & PRESCRIPTION ORDER FORM

Use black ink only. Enclose form with prescription(s) and payment.

<b>#1 MEMBER INFORMATION</b>		<input type="checkbox"/> Male	<input type="checkbox"/> Prescription(s) enclosed for this patient		
		<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs snap-on caps		
ID Number (Important)	1 2 3 - 4 5 - 6 7 8 9	Suffix extension if on ID card			
Name (First, Last) JOHN Q SAMPLE		Date of Birth (MM/DD/YYYY) / /			
Shipping Address (Please do not use P.O. Box) 123 MAIN STREET		Daytime Phone ( )			
City ANYTOWN, US 12345	State	ZIP Code	Evening Phone ( )		
E-mail Address		Dr. Name	Dr. Phone (Required) ( )		
<b>ALLERGIES:</b>		<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin	
<input type="checkbox"/> 87-Sulfa		<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):		
<b>HEALTH CONDITIONS:</b>		<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension	
<input type="checkbox"/> 400-Heart disease		<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders		
<input type="checkbox"/> 700-Thyroid disease		<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):		
<b>PAYMENT – CHECK OR CREDIT CARD (VISA, MasterCard, Discover, American Express)</b>					
<input type="checkbox"/> By checking this box, I elect to receive brand drugs for all prescriptions in this order whenever possible. <b>By making this choice, I understand that under my benefit plan, I will be responsible for the higher brand copayment for each drug.</b>		Rx Type	No.	Cost (ea.)	Subtotal
		Generic		*	\$
		Preferred		*	\$
		Non-Preferred		*	\$
					\$
		<b>TOTAL AMOUNT ENCLOSED</b>			\$
Credit Card Number					
Credit Card Expiration (MM/YY) /					
*Refer to the back page of your Card Carrier for copayments.					
Mail to: Walgreens Healthcare Plus P.O. Box 29061, Phoenix, AZ 85038-9061					

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Turn page and complete dependent info. on the other side of this form.

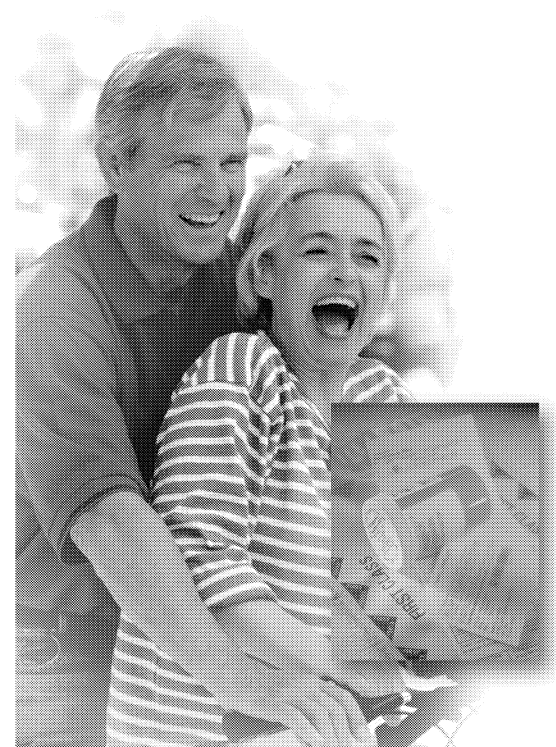
<b>#2 DEPENDENT INFORMATION</b>		<input type="checkbox"/> Male	<input type="checkbox"/> Prescription(s) enclosed for this patient
<input type="checkbox"/> Suffix extension if on ID card		<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs snap-on caps
Name (First, Last)		Date of Birth (MM/DD/YYYY)	
Shipping Address (if different than member )		Daytime Phone	
		( )	
City	State	ZIP Code	Evening Phone
			( )
E-mail Address		Dr. Name	Dr. Phone (Required)
			( )
<b>ALLERGIES:</b>	<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin
<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	
<b>HEALTH CONDITIONS:</b>	<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension
<input type="checkbox"/> 400-Heart disease	<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders	
<input type="checkbox"/> 700-Thyroid disease	<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):	
<b>#3 DEPENDENT INFORMATION</b>		<input type="checkbox"/> Male	<input type="checkbox"/> Prescription(s) enclosed for this patient
<input type="checkbox"/> Suffix extension if on ID card		<input type="checkbox"/> Female	<input type="checkbox"/> Patient needs snap-on caps
Name (First, Last)		Date of Birth (MM/DD/YYYY)	
Shipping Address (if different than member )		Daytime Phone	
		( )	
City	State	ZIP Code	Evening Phone
			( )
E-mail Address		Dr. Name	Dr. Phone (Required)
			( )
<b>ALLERGIES:</b>	<input type="checkbox"/> No known	<input type="checkbox"/> 32-Codeine	<input type="checkbox"/> 70-Penicillin
<input type="checkbox"/> 87-Sulfa	<input type="checkbox"/> 93-Tetracycline	<input type="checkbox"/> Other (list):	
<b>HEALTH CONDITIONS:</b>	<input type="checkbox"/> No known	<input type="checkbox"/> 200-Diabetes	<input type="checkbox"/> 300-Hypertension
<input type="checkbox"/> 400-Heart disease	<input type="checkbox"/> 500-Glaucoma	<input type="checkbox"/> 600-Stomach disorders	
<input type="checkbox"/> 700-Thyroid disease	<input type="checkbox"/> 800-Arthritis	<input type="checkbox"/> Other (list):	

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# Mail Service Pharmacy Order Form

New Prescription Orders



Providing convenience for your prescription drug needs...

*Walgreens*  
**HEALTH**  
INITIATIVES

## Mail Pharmacy Customer Service:

1-888-265-1953

(TTY: 1-800-573-1833)

Monday-Friday, 7 a.m. – 7 p.m. (Mountain)

Saturday, 7 a.m. – Noon (Mountain)

## Refills by Phone:

1-800-RX-REFILL (1-800-797-3345)

(en español: 1-800-778-5427)



## Internet:

www.whphi.com

Thank you for your order.

**Please Note:** By submitting this form, you have authorized release of all information to Walgreens Healthcare Plus (and other necessary parties) as required to process your prescriptions and their refills under your benefit plan.

## FRONT

		Maricopa County
<b>PRESCRIPTION DRUG PROGRAM</b>		
RxBIN	603286	
RxPCN	01410000	
RxGrp	512229	
Issuer		
Name	<b>JOHN Q SAMPLE</b>	
ID	<b>123456789</b>	

## BACK

<b>PLEASE PRESENT THIS CARD EACH TIME YOU VISIT A PARTICIPATING RETAIL PHARMACY</b>	
<b>TERMS AND CONDITIONS</b>	
<p>This card is non-transferable and is for identification purposes only. It is not a guarantee of coverage. The terms of the agreement between Walgreens Health Initiatives and the insuring organization govern all prescription benefits obtained through use of this card, which is the sole property of Walgreens Health Initiatives. Any fraudulent or unauthorized use of this card is strictly prohibited by law.</p> <p>When your eligibility terminates, this card is void.</p>	
<b>WHI Member Services:</b> 1-800-207-2568 <a href="http://www.whphi.com">www.whphi.com</a>	<b>Submit UCF Claims to:</b> Walgreens Health Initiatives P.O. Box 545 Deerfield, IL 60015